Part-Time Student / Dependent Health Service Plus Enrollment/Change Request

Plans are underwritten by Aetna Life Insurance Company.

Group Information – *To be completed by Aetna Student Health.*
Group Name **RUTGERS UNIVERSITY-2009/2010- PART-TIME STUDENT & DEPENDENT** [Control Number] **474876**_________ Policy Number ____________________

A. Type of Activity – *To be completed by Rutgers University. Refer to instructions on Page 3 before completing this form. Print clearly.*

Activity – *Check all that apply*	**Effective Date/ Date of Event**	**Date of Enrollment/Reason for Change**
1. Add		
☐ Enrollment of a New Student	______ / _____ /_______	______________________________
☐ Add Spouse/Civil Union Partner	______ / _____ /_______	______________________________
☐ Add Dependent Child	______ / _____ /_______	______________________________
2. Remove		
☐ Student Withdrawal/Termination	______ / _____ /_______	______________________________
☐ Remove Spouse/Civil Union Partner	______ / _____ /_______	______________________________
☐ Remove Dependent Child	______ / _____ /_______	______________________________
3. Change		
☐ Name Change	______ / _____ /_______	______________________________
☐ Change Plan	______ / _____ /_______	______________________________
☐ Other	______ / _____ /_______	______________________________

[B. Student Information – *To be completed by the Student.*

Name (Last, First, MI) ____ Student ID# orSS#______________

U.S. Home Address ______________________________ Apt. No.__________

City ______________________________ State ______________ ZIP Code________________

Home Telephone ______________________________ [E-mail Address ______________________________

Birthdate ______________________________ Sex ☐ Male ☐ Female

C. Plan Options – *To be completed by the Student. Check the box that indicates the level of coverage you want.*
Please note: Spouse/Civil Union Partner and Dependent children must purchase the exact same coverage as the Insured student

474876	**A**	**B**
<u>Enroll here if adding to Health Service Plus ONLY</u> Basic Plan-Health Service Plus-- ($5,000 per condition)	**Fall** **9/1/09-1/18/10** **Deadline: 5/21/10**	**Spring/Summer** **1/19/10-8/31/10** **Deadline: 5/21/10**
1A. Student-**Camden** 474876-HSC12	( ) **$173.50**	( ) **$173.50**
1B. Student-**Newark** 474876-HSN12	( ) **$141.75**	( ) **$141.75**
1C. Student-**New Brunswick** 474876-HSB12 2. Spouse/Civil Union Partner	( ) **$181.00** ( ) **$730.00**	( ) **$181.00** ( ) **$1,036.00**
3. Each Child	( ) **$331.00**	( ) **$497.00**

D. Other Individuals Covered – *To be completed by Student. Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and date. Attach proof if full-time post-secondary student. Attach proof of disability.*

1. Spouse or Civil Union Partner	2. Child	3. Child	4. Child
☐ Add ☐ Other ☐ Remove ☐ Continue Spouse	☐ Add ☐ Other ☐ Remove ☐ Continue	☐ Add ☐ Other ☐ Remove ☐ Continue	☐ Add ☐ Other ☐ Remove ☐ Continue
Name Last ____ First ____ MI ___ Birthdate (mm/dd/yyyy) ____ / ____ / ____ Social Security Number ____	Name Last ____ First ____ MI ___ Birthdate (mm/dd/yyyy) ____ / ____ / ____ Social Security Number ____	Name Last ____ First ____ MI ___ Birthdate (mm/dd/yyyy) ____ / ____ / ____ Social Security Number ____	Name Last ____ First ____ MI ___ Birthdate (mm/dd/yyyy) ____ / ____ / ____ Social Security Number ____
Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name ____ Policy # ____ Medicare ID# ____	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name ____ Policy # ____ Medicare ID# ____	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name ____ Policy # ____ Medicare ID# ____	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name ____ Policy # ____ Medicare ID# ____
Previous Coverage ☐ Yes ☐ No *If yes:* Effective Date ____ / ____ / ____ Termination Date ____ / ____ / ____ Payer Name ____ Policy # ____ *[Submit a copy of the Certificate of Creditable Coverage.]*	Previous Coverage ☐ Yes ☐ No *If yes:* Effective Date ____ / ____ / ____ Termination Date ____ / ____ / ____ Payer Name ____ Policy # ____ *[Submit a copy of the Certificate of Creditable Coverage.]*	Previous Coverage ☐ Yes ☐ No *If yes:* Effective Date ____ / ____ / ____ Termination Date ____ / ____ / ____ Payer Name ____ Policy # ____ *[Submit a copy of the Certificate of Creditable Coverage.]*	Previous Coverage ☐ Yes ☐ No *If yes:* Effective Date ____ / ____ / ____ Termination Date ____ / ____ / ____ Payer Name ____ Policy # ____ *[Submit a copy of the Certificate of Creditable Coverage.]*
Employed? ☐ Yes ☐ No *If yes, complete Section [E]1.*	If last name is different from Student's, please explain: ____	If last name is different from Student's, please explain: ____	If last name is different from Student's, please explain: ____
Home or billing address same as Student? ☐ Yes ☐ No *If NO, complete Section [E]2.*	Living with Student? ☐ Yes ☐ No *If NO, complete Section [F].*	Living with Student? ☐ Yes ☐ No *If NO, complete Section [F].*	Living with Student? ☐ Yes ☐ No *If NO, complete Section [F].*

[E.] Additional Spouse/Civil Union Partner Information – *To be completed by Student. If not applicable, please mark as "NA."*

1. Employer Name ____ Telephone ____

   Employer Address ____ ____

   City ____ ____ State ____ ZIP Code ____

2a. Street/Apt ____ ____

   City ____ ____ State ____ ZIP Code ____

2b. Please explain why the address is different ____

[F.] Additional Child Information – *To be completed by Student. Provide information below about children listed in Section D, **if** they have a different address from the student. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s) ____
Street/Apt. ____
City ____ State ____ ZIP Code ____
Reason ____

Name(s) ____
Street/Apt. ____
City ____ State ____ ZIP Code ____
Reason ____

[G.] Race/Ethnicity – *To be completed by Student, at his/her option. NOTE: your response is appreciated but NOT required!*

Choose a category that most closely describes you:

- ☐ American Indian or Alaskan Native
- ☐ Black, not of Hispanic origin
- ☐ Hispanic
- ☐ Asian or Pacific Islander
- ☐ White, not of Hispanic origin

[H.] Student Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request.

Signature ______________________________ Date _______ / _______ / _______

[I.]Rutgers University Verification

The requested activity is believed eligible and is approved by Rutgers University.

Rutgers University Representative ______________________________ Date _______ / _______ / _______

Representative's Title ______________________________

INSTRUCTIONS

RutgersUniversity – You must complete the Rutgers group information and Sections A and [I].

STUDENTS – You must complete Sections B through [H].

- Please PRINT except when a signature is requested.
- [If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.]

Qualifying Events

Dependent Under 31

D1. Loss of dependent status and otherwise eligible

D2. Reestablish eligibility: residency

D3. Reestablish eligibility: nonresident full-time student

D4. Reestablish eligibility: change in marital status

D5. Reestablish eligibility: change in parental status

D6. Reestablish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT – STUDENT ACKNOWLEDGEMENT AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request for, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, and any employer to give Aetna Student Health, acting on behalf of Aetna Life Insurance Company, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Aetna Life Insurance Company has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Aetna Life Insurance Company will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize payments as follows:

   Make check or money order payable to Aetna Student Health and forward the check to the designated entity authorized to receive the payment or refer to the charge card authorization to charge the cost of your coverage

   to Visa or MasterCard and the designated entity will process the charge card debit.

   CREDIT CARD AUTHORIZATION – PLEASE PRINT CLEARLY. (VISA OR MASTERCARD ARE THE ONLY ACCEPTED CREDIT CARDS.)

   Credit Card # (Visa or MasterCard only): ______________________________ Expiration Date: _____ / _____

   Signature of Cardholder ______________________________

   ____

   Printed Name and Address (if different from student) ______________________________

   ____